Supreme Court, U. S.
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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1976

No. 76-141

ST. LOUIS UNIVERSITY,
Petitioner,

v.

BLUE CROSS HOSPITAL SERVICE, INC. OF ST. LOUIS, d/b/a BLUE CROSS PLAN OF ST. LOUIS; BLUE CROSS ASSOCIATION; and SECRETARY OF HEALTH, EDUCATION AND WELFARE,
Respondents.

PETITION FOR A WRIT OF CERTIORARI

To the United States Court of Appeals for the Eighth Circuit

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St. Louis University, petitioner herein, respectfully prays that a Writ of Certiorari be issued to review the judgment of the United States Court of Appeals for the Eighth Circuit entered in this action on April 12, 1976.

OPINIONS BELOW

The opinion of the United States District Court for the Eastern District of Missouri, reported at 393 F.Supp. 367, is reproduced in Appendix A, *infra*. The opinion of the Court of

Appeals, reported at 3 CCH Medicare and Medicaid Guide ¶ 27,788, and not yet reported in the Federal Reporter, is reprinted in Appendix B, *infra*.

JURISDICTION

The opinion and judgment of the Court of Appeals were filed on April 12, 1976. Petitioner's timely petition for rehearing and rehearing en banc was denied on May 4, 1976 (Appendix C, *infra*). This petition was filed within 90 days of May 4, 1976.

Jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

QUESTIONS PRESENTED

1. Should the dictum in *Weinberger v. Salfi*, 422 U.S. 749 (1975), to the effect that 42 U.S.C. § 405(h) precludes review of Social Security Act claims under 28 U.S.C. § 1331(a) be extended to preclude judicial review of an erroneous interpretation and application of the express provisions of the Medicare Act by the administering agency, particularly where the result of such an extension would be to prevent judicial review in a large category of cases under the Medicare Act and accord absolute finality to the agency's decision on a question solely of law?

2. Does the Medicare Act commit the interpretation of its provisions solely to the discretion of the administering agency, with no right to judicial review under the Administrative Procedure Act of a clearly erroneous interpretation of the Medicare Act by the agency?

3. Can reimbursement under Part B of the Medicare Act be arbitrarily limited by the administering agency, acting through

a private entity, to the dollar salaries paid to physicians by the University operating the teaching hospital in which the physicians are employed, despite the fact that 42 U.S.C. § 1395l requires that such reimbursement be based upon the "reasonable charges" to the patients for the physicians' services?

STATUTES INVOLVED

The relevant portions of the substantive statutes involved in this case, 5 U.S.C. §§701(a), 702 and 704, 28 U.S.C. § 1331(a), 42 U.S.C. §§ 405(g) and 405(h), and 42 U.S.C. §§ 1395l and 1395u are set forth in Appendix D, *infra*.

STATEMENT OF THE CASE

St. Louis University is a metropolitan university. Its operations include a School of Medicine. As an adjunct to the School of Medicine, the University owns and operates a general hospital and a psychiatric unit (hereinafter collectively referred to as the "hospital"). The hospital is adjacent to the School of Medicine and its affiliation with the School of Medicine is essential to its function as a teaching and training facility for physicians.

The University employs certain physicians on a full time basis and pays those physicians stipulated salaries. The physicians provide professional services to the patients at the hospital. The physicians intended, and the University intended, that the excess of the reasonable charges for the physicians' services over the amount of the physicians' salaries would inure to the benefit of the School of Medicine. The charges to Medicare patients for the professional services of the physicians are no greater and no less than the charges to non-Medicare patients for the same services. In the case of Medicare patients, the physicians'

charges are reimbursable under Part B of the Medicare Act (42 U.S.C. §§ 1395j-1395w).[1]

The University based its claim for reimbursement under Part B of the Medicare Act for the professional services of certain of its physicians in the years 1966, 1967 and 1968 upon a schedule of reasonable charges for those services. The carrier charged with administering the Part B program for the hospital (General American Life Insurance Company) accepted the charges as reasonable and paid the University's billings for the services. However, Blue Cross Hospital Service, Inc. (hereinafter "Blue Cross"), which has responsibility for auditing Medicare payments, charged against the University's Part A claim for reimbursement the excess of the charges for the professional services of the physicians over the total dollar salary paid by the University to the physicians which had not been allocated to services rendered to the hospital.[2] In determining to limit the University's Part B reimbursement to the dollar salaries of its physicians, Blue Cross was guided and controlled by the Blue Cross home office in Chicago.

The basic dispute between the University and Blue Cross is therefore as follows:

> *The University's Position:* The University claims that the full *reasonable charges* for the professional services rendered to patients at the hospital by all physicians in the full time employ of the University are reimbursable charges under Part B of the Medicare Act.[3]

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[1] In general, Part A of the Medicare Act provides for the payment of costs of hospitalization insured under the Medicare program and Part B provides for the payment of charges for physicians' services insured under the program.

[2] Blue Cross did not, and does not, dispute the fact that the charges contained in the University's schedule are reasonable.

[3] This right of reimbursement belongs to the University rather than the physicians under arrangements between the University and the physicians whereby the latter have transferred their Part B reimbursement rights to the University.

> *Blue Cross' Position:* The position of Blue Cross is that, insofar as certain of the physicians in the employ of the University are concerned (radiologists, pathologists, anesthesiologists and others), the amount to be reimbursed for the professional services of those physicians is not to be measured by the reasonable charges for their services, but is to be an amount which cannot exceed *the cost to the hospital* for such services, *i.e.* the amount of the salaries paid to the physicians by the University.

The University contends, *inter alia*, that Blue Cross' attempted limitation on the right of the University to receive reimbursement based upon the reasonable charges for the services rendered by certain of its physicians is directly contrary to the unambiguous provisions of the Medicare Act which state that reimbursement for such professional services must be made on the basis of the "reasonable charges" for the services. 42 U.S.C. §§ 1395l, 1395u (pp. A-31-32, *infra*).

The University appealed Blue Cross' determination to the Blue Cross Association Provider Appeals Committee. That Committee is composed of five members, three of whom must be Blue Cross Association employees and one of whom must be a Blue Cross Association vice-president. The Committee held a hearing on May 10, 1972, and rendered a decision on August 16, 1972, denying the University's appeal. The University thereupon brought an action under the Administrative Procedure Act (5 U.S.C. §§ 702-06) and 28 U.S.C. § 1331(a) in the United States District Court for the Eastern District of Missouri seeking review of the Committee's decision.

On February 18, 1975, the District Court issued its opinion holding that it was barred by the doctrine of sovereign immunity from reviewing the Committee's decision on its merits. The District Court went on to hold, however, that the Committee was improperly constituted and remanded the case for a de novo

evidentiary hearing before an impartial tribunal. All parties appealed the District Court's decision to the Court of Appeals.

The Court of Appeals issued its opinion on April 12, 1976, holding that jurisdiction of the University's appeal under 28 U.S.C. § 1331(a) was barred by this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975) and that jurisdiction under the Administrative Procedure Act was precluded because the Medicare Act committed the issues raised in the University's appeal to the absolute discretion of the agency. The Court of Appeals further held that the makeup of the Provider Appeals Committee was constitutionally permissible but that the action should be remanded to the Secretary of Health, Education and Welfare for a final administrative interpretation of the Medicare Act and the regulations thereunder insofar as the Act and regulations relate to the issue raised in the University's appeal.[4] If the Opinion of the Court of Appeals is allowed to stand, the Secretary's interpretation of the Medicare Act and the regulations thereunder cannot be reviewed.

The University filed a timely petition for rehearing and rehearing en banc, which was denied on May 4, 1976. On May 10, 1976, the panel of the Court of Appeals, on its own motion, modified its opinion with respect to certain language not here relevant.

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[4] On the same day, the Court of Appeals rendered a similar decision in the companion case of *Faith Hospital Association v. Blue Cross Hospital Service*, 3 CCH Medicare and Medicaid Guide ¶ 27,789 (8th Cir. 1976). That decision was based upon the opinion in this action. Faith Hospital Association has filed a petition for a Writ of Certiorari, No. 76-105.

REASONS WHY THE WRIT SHOULD BE GRANTED

The Court of Appeals' opinion formulates some unique principles which are in conflict with decisions in other Circuits and which, if allowed to stand unreviewed, could have a significant influence in cases arising under the Medicare Act and the Administrative Procedure Act. The opinion raises important questions concerning the jurisdiction of the federal courts.

I. There Is a Direct Conflict Between the Eighth Circuit and the Court of Claims as to Whether Certain Language in Weinberger v. Salfi Should Be Expanded to Preclude Nonstatutory Review of Agency Decisions Under the Medicare Act.

In declining to exercise jurisdiction in this case, the Court of Appeals interpreted *Salfi* as holding that 42 U.S.C. § 405(h) precludes review under 28 U.S.C. § 1331(a) of agency decisions under the Social Security Act (p. A-16, *infra*). The Court of Appeals went on to hold that:

> "The considerations which led Congress to limit review under the Social Security Act apply with equal force to the Medicare program." (p. A-17, *infra*)

In *Whitecliff, Inc. v. United States*, 3 CCH Medicare and Medicaid Guide, ¶ 27,819 (Ct. Cl. 1976) (Appendix E, *infra*), the Court of Claims, in a well reasoned opinion, reached exactly the opposite conclusion. That case, like the instant action, concerned the proper reimbursement of a Medicare provider. There, the court stated:

> "We decline the invitation to extend *Salfi's* reading of Section 405(h) to this Medicare case." (p. A-37, *infra*)

Thus, there is a direct conflict between the Eighth Circuit and the Court of Claims as to whether the preclusion of review

contained in dicta in *Salfi* should be extended to Medicare Act cases.[5]

It is respectfully submitted that the *Whitecliff* decision is correct. A careful reading of *Salfi* indicates that a determination whether 42 U.S.C. §405(h) precludes review in situations not covered by 42 U.S.C. §405(g) was *not* necessary to the Court's decision. Rather, the actual holding was only that review was available under 42 U.S.C. § 405(g) if administrative remedies were exhausted. Therefore, the preclusion of review in *Salfi* was indeed dicta and should *not* be expanded. In addition, the holding in *Salfi* was expressly limited by the Court to Social Security Act claims. With regard to 42 U.S.C. §405(h), the Court stated *l.c.* 756-57:

> "On its face, this provision bars district court federal-question jurisdiction over suits, such as this one, *which seek to recover Social Security benefits.*" (emphasis supplied)

Nowhere in the opinion in *Salfi* does the Court imply that the above quoted jurisdictional bar should be expanded to include Medicare Act cases. Moreover, an application of *Salfi's* preclusion of review in Medicare Act cases would have far different results than those envisioned in *Salfi*. The undesirable results of such an application were articulated in *Whitecliff*:

> "The social security provisions with which the Supreme Court dealt in *Salfi* authorize appeals of all decisions made after hearings, with out limitation as to issues . . . By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers. *To import into*

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[5] Other courts have rightly refused to expand the dicta in *Salfi*. *Humana of South Carolina, Inc. v. Mathews*, 3 CCH Medicare and Medicaid Guide ¶ 27,856 (D.D.C. 1976). *See also Ryan v. Shea*, 525 F. 2d 268, 272 (10th Cir. 1975); *Plato v. Roudebush*, 397 F. Supp. 1295, 1314, n. 3 (D. Md. 1975).

> *the Medicare program the Salfi preclusion of judicial review (except as expressly authorized) would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA.*" (emphasis supplied) (p. A-37, *infra*)

The result predicted in *Whitecliff* has occurred in the instant action. Under the principles enunciated by the Eighth Circuit, there is absolutely no way to obtain review of the agency's decision. Thus, the Court of Appeals' expansion of the dicta in *Salfi* was patently erroneous and should be reviewed.

II. There Is a Direct Conflict Among the Circuits as to Whether Agency Interpretations of the Medicare Act Are Committed by Law to Agency Discretion.

The Court of Appeals held that it lacked jurisdiction under the Administrative Procedure Act to review the University's appeal because it felt that the agency's decision was committed by Congress to agency discretion (p. A-19, *infra*). That holding is squarely in conflict with holdings in the Second, Fifth and Ninth Circuits and with numerous other decisions throughout the country. In considering the reviewability of Medicare Act determinations under the Administrative Procedure Act, the Second Circuit, in *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 668 (2d Cir. 1973), stated:

> "Accordingly, we find no prohibition [by Congress], express or implied, against judicial review of Kingsbrook's claim under the APA."

In *Rothman v. Hospital Service of Southern California*, 510 F.2d 956, 959 (9th Cir. 1975), the Ninth Circuit said:

> "The general principle therefore applies that A.P.A. review [of agency decisions under the Medicare Act] is available because Congress has not indicated that it should not be."

Most recently, in *Dr. John T. MacDonald Foundation, Inc. v. Mathews*, 534 F.2d 633 (5th Cir. 1976), the Fifth Circuit held that "Congress did not intend to commit such decisions [under the Medicare Act] to agency discretion." *Id.* at 636, n. 6. *Accord, Temple University v. Associated Hosp. Serv. of Philadelphia*, 361 F.Supp. 263 (E.D. Pa. 1973); *Columbia Heights Nursing Home & Hospital, Inc. v. Weinberger*, 380 F.Supp. 1066 (M.D. La. 1974); *Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger*, 376 F.Supp. 1099 (S.D. Fla. 1974), *rev'd on other grounds*, 517 F.2d 329 (5th Cir. 1975); *St. John's McNamara Hosp. v. Associated Hospital Service, Inc.*, 410 F. Supp. 67, 73-75 (D.S.D. 1976). *See also Maddox v. Richardson*, 464 F.2d 617, 619-22 (6th Cir. 1972); *Davis v. Richardson*, 460 F.2d 772, 775 (3d Cir. 1972).

The Court of Appeal's decision in this action is also in conflict with the teachings of this Court in *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971), *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967) and *Rusk v. Cort*, 369 U.S. 367 (1962). Those cases held that there is a presumption of reviewability under the Administrative Procedure Act which should not be disregarded in the absence of clear and convincing evidence that Congress so intended. Here, there is *no* clear and convincing legislative intent to preclude review of the issues raised in the University's appeal. The Court of Appeals for the Second, Fifth and Ninth Circuits have so held in *Kingsbrook*, *MacDonald* and *Rothman*.

In denying review under the Administrative Procedure Act in this action, the Court of Appeals has acted in contravention

of the mandate of this Court and is clearly out of step with the overwhelming weight of authority in other jurisdictions. Its decision should therefore be reviewed.[6]

III. This Case Raises Issues of Major Importance Concerning the Administration of the Medicare Program and the Jurisdiction of the Federal Courts.

The decision in this appeal is of importance to teaching hospitals all over the country. Those institutions are currently being treated in a discriminatory fashion under the Medicare Act. At virtually every other type of private hospital, practicing physicians are reimbursed (properly under the Medicare Act) on the basis of their reasonable charges, yet reimbursement to teaching hospitals (which generally are the hospitals that employ salaried physicians) on the same basis is denied, to the detriment of the educational and medical services those hospitals provide. In addition, the Medicare Part B insurance fund is enjoying a windfall at the expense of the teaching hospitals which was not contemplated by the Medicare Act. The Federation of American Hospitals appeared below as amicus curiae in support of the University's position because of the general importance of the question to other institutions similarly situated. In addition, counsel for the University have had inquiries and support from numerous lawyers whose clients will be adversely affected if the Court of Appeals' decision remains unchanged.[7]

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[6] It should be noted that even if the determination of the *amount* of benefits under Part B of the Medicare Act should be considered as a matter best left to agency expertise, the issue in this case does not involve any resolution of *amount* of benefits. Rather the issue is the proper interpretation of the Medicare Act. Whether, when the Act requires reimbursement on the basis of the "reasonable charges" made to patients for the services of the physician, the agency can substitute the cost to the hospital, *i.e.*, the physician's salary, as the basis for such reimbursement.

[7] It is anticipated that respondents might argue that 42 U.S.C. § 1395 oo (enacted in 1972) creates a Provider Reimbursement Review Board the decisions of which are reviewable under the Admin-

This case raises grave questions of statutory interpretation. If review of agency interpretations of the Medicare Act is precluded, the agency would be permitted to fulfill its every whim unfettered by judicial restraint and the hospitals in this country would be powerless to obtain relief from any unfairness that might occur. It is inconceivable that an interpretation of a federal act by a federal agency could not be reviewed by a federal court. Yet, that is what the opinion in this case would provide. Such a result was surely not intended by Congress.

CONCLUSION

For the reasons stated, the petition for Writ of Certiorari should be granted.

Respectfully submitted,

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istrative Procedure Act and that the jurisdictional issues in this case are therefore no longer important. Such an argument is without merit. Section 1395 oo applies only to accounting periods ending on or after June 30, 1973. Litigation concerning years prior to 1973 has only begun and the courts will need guidance concerning the jurisdictional issues that will be raised in numerous future cases. In addition, the final unreviewed determination by the Secretary of Health, Education and Welfare of the merits of the University's appeal will set a precedent for future determinations under Part B of the Medicare Act.